

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157015</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/21/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>VISITING NURSE ASSOCIATION OF THE WABASH VALLEY IN</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 8TH AVE</b> <b>TERRE HAUTE, IN 47804</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{G 000}	<p>INITIAL COMMENTS</p> <p>This was a revisit for the Federal recertification survey completed on 2/6/2014 that resulted in an extended survey.</p> <p>Survey Date: 03/21/14</p> <p>Facility #: 005253</p> <p>Medicaid Vendor #: 100272050</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Three (3) conditions and 17 standards were found to be corrected as a result of this survey.</p> <p>Visiting Nurse Association of the Wabash Valley is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 2/12/14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of patients, plan of care and medical supervision, 484.30 Skilled Nursing Services, and 484.32 Therapy Services.</p> <p>The Administrator, Director of Nursing and the Nursing Supervisor were informed of this preclusion during the exit conference held on 3/21/14 at 4:15 PM.</p> <p>Current Census: 233</p> <p>Visiting Nurse Association of the Wabash Valley is in compliance with the Conditions of Participation 42 CFR 484.</p>			{G 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{G 000}	Continued From page 1 Quality Review: Joyce Elder, MSN, BSN, RN March 25, 2014	{G 000}			